EXHIBIT 2 HUH
DATE 1-14-09
HB 105

Statement regarding House Bill 105 provided to the House Human Services Committee on January 14, 2009

Madam Chair, Members of the Committee: My name is Steven Helgerson. I am the State Medical Officer.

I, too, wish to thank Representative Kottel for sponsoring this very important legislation.

Todd Harwell nicely summarized the key elements of this bill and highlighted ways that both hospital and emergency department (ED) discharge data could be used to inform policy, plan programs, identify opportunities to improve the health of Montanans, and evaluate the efficacy of efforts to prevent preventable conditions.

I will, briefly, illustrate some ways that hospital and ED discharge data would be used.

First, as Todd mentioned, a limited hospital discharge data set is currently maintained by the Montana Hospital Association (MHA). The MHA deserves great credit for beginning to demonstrate that these data can be collected and do have usefulness. During the 6-year period 2000 to 2005, 4256 hospitalizations due to asthma were recorded by the MT hospitals participating in the MHA's system. FIGURE 1 displays the rate (per 10,000 persons) of hospitalization due to asthma for six age groups. Consistent with national data, the asthma hospitalization rates were highest for the very young and the very old.

[The available data set does not include individual identifiers. Therefore, it was not possible with this data set to disaggregate the data to assess the frequency and timing of re-hospitalization of the same person once an initial hospitalization occurred. Doing so would potentially provide information that public health and other health care providers could use to intervene to prevent re-hospitalizations. If HB105 were passed, hospitalization patterns such as this could be determined.]

Second, because asthma leads to much more outpatient and ED use than it does to hospitalization, more important asthma prevention targets would be identified through use of ED data. While statewide ED data for the entire MT population are not now available, we have begun assessing ED data that are available for a subset of the MT population, specifically—Medicaid children with asthma. In 2005-2006, 2019 (8.8%) of the 22,870 children (aged 0 to 18 years) who were continuously enrolled in the MT Medicaid program had asthma.

FIGURE 2 displays the rate (per 100 children with asthma) of ED use by these children in 8 geographic regions of the state. The 3-fold variation in ED use (from 21 visits per 100 children in the southwest region to 67 visits per 100 in the northwest region) is striking for this population. While we do not have time today to discuss the additional work that our Asthma Control Program is doing to understand these patterns better and to develop prevention strategies, suffice it to say that it is important to assess the ED utilization for all Montanans with asthma, not just Medicaid children with asthma. This would become possible if HB105 were passed.

[NOTE: I would like to thank the 2007 Legislature for providing the funds that allowed us to establish an Asthma Control Program in MT. Materials produced by this Program (which has invaluable support from an Advisory Group consisting of MT clinicians, educators, and others) are available at www.dphhs.mt.gov/asthma]

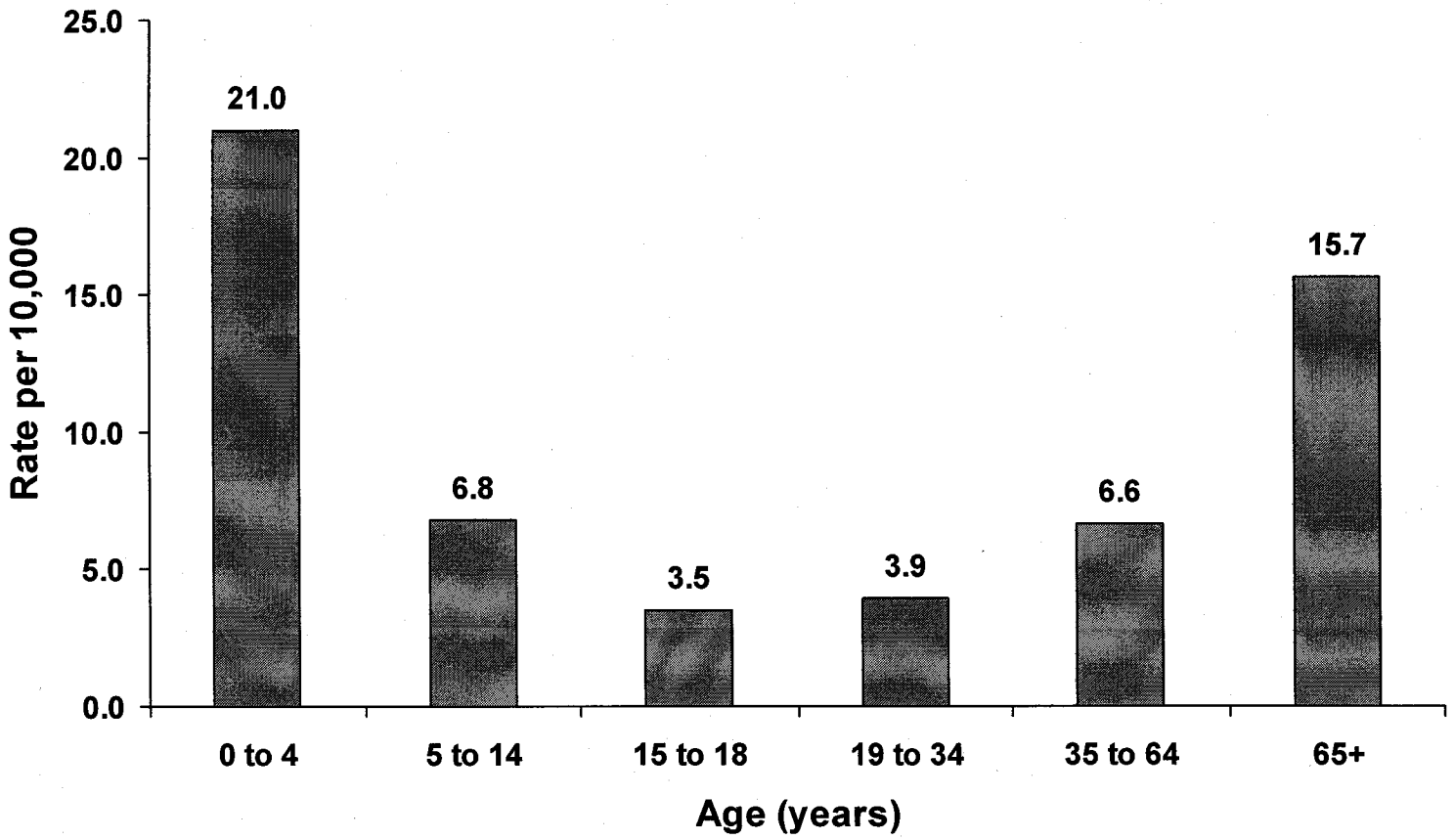
Finally, one other example of how hospital discharge data can be used when a complete, thorough data set is available is shown in FIGURE 3. Investigators have used a national hospitalization file to describe the rate of hospitalization due to injuries. In 2004 the overall injury hospitalization rate in the U.S. was higher in rural than in urban areas. Furthermore, thorough hospital discharge data allowed looking more specifically at the types of injury that lead to this difference. Unintentional injuries, particularly due to falls and motor vehicle trauma, are problems waiting for targeted prevention strategies. The injury issue needs attention in MT. With hospital and ED discharge data available for our state, we can begin to develop, implement and evaluate strategies to decrease the burden of injury---which incidentally, is the leading cause of death for Montanans aged 1 to 44.

I appreciate the opportunity to share these comments with you.

Steven D. Helgerson, MD,MPH
State Medical Officer

Attachments

Figure 1. Hospitalization rates from asthma (primary diagnosis) per 10,000 by age, Montana, 2000-2005.+



+Data source - Hospital discharge data, Montana Hospital Association.

Figure 2. Rate of ED visits per 100 children with probable asthma continuously enrolled in Montana Medicaid from by region, 2005-2006

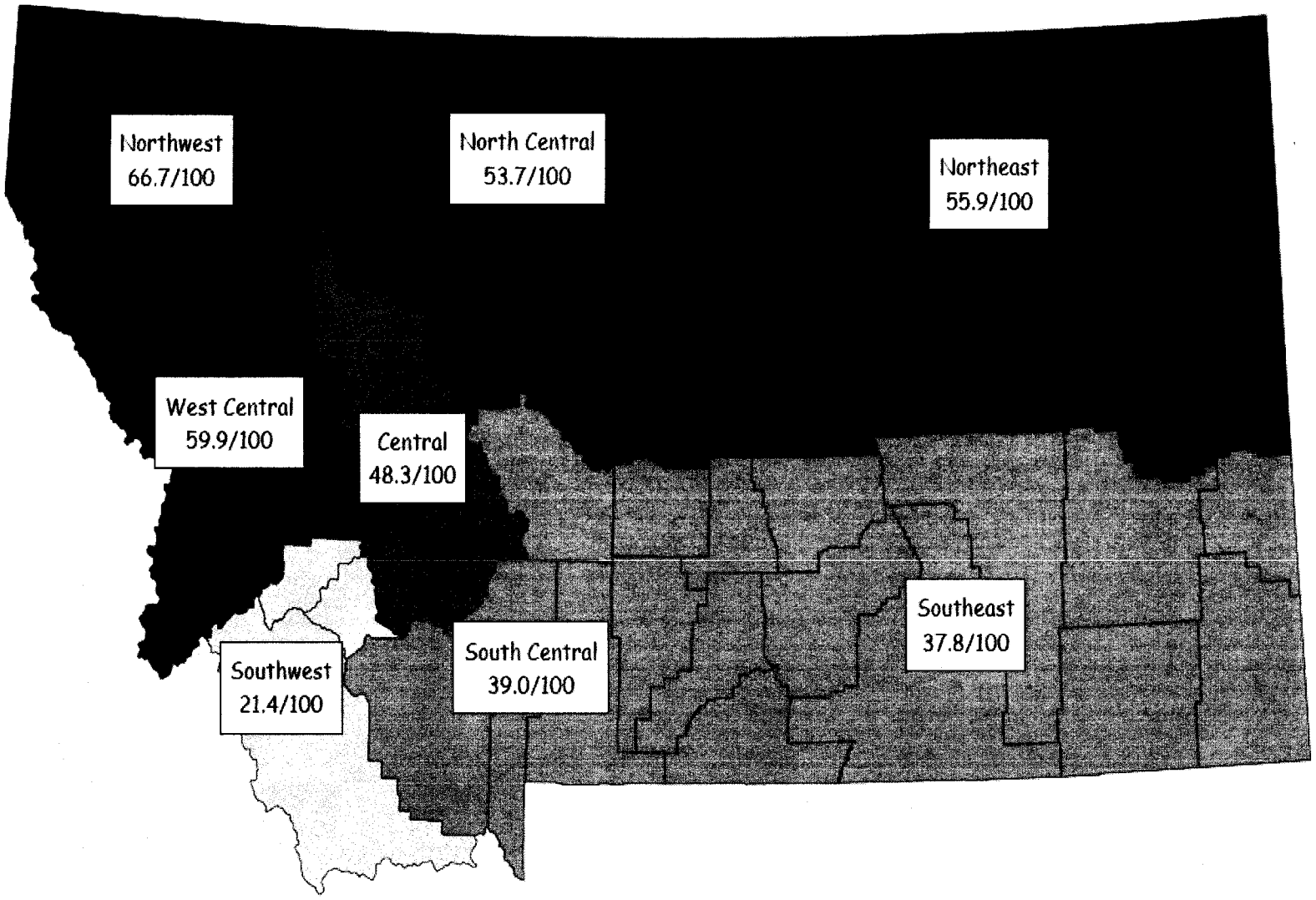
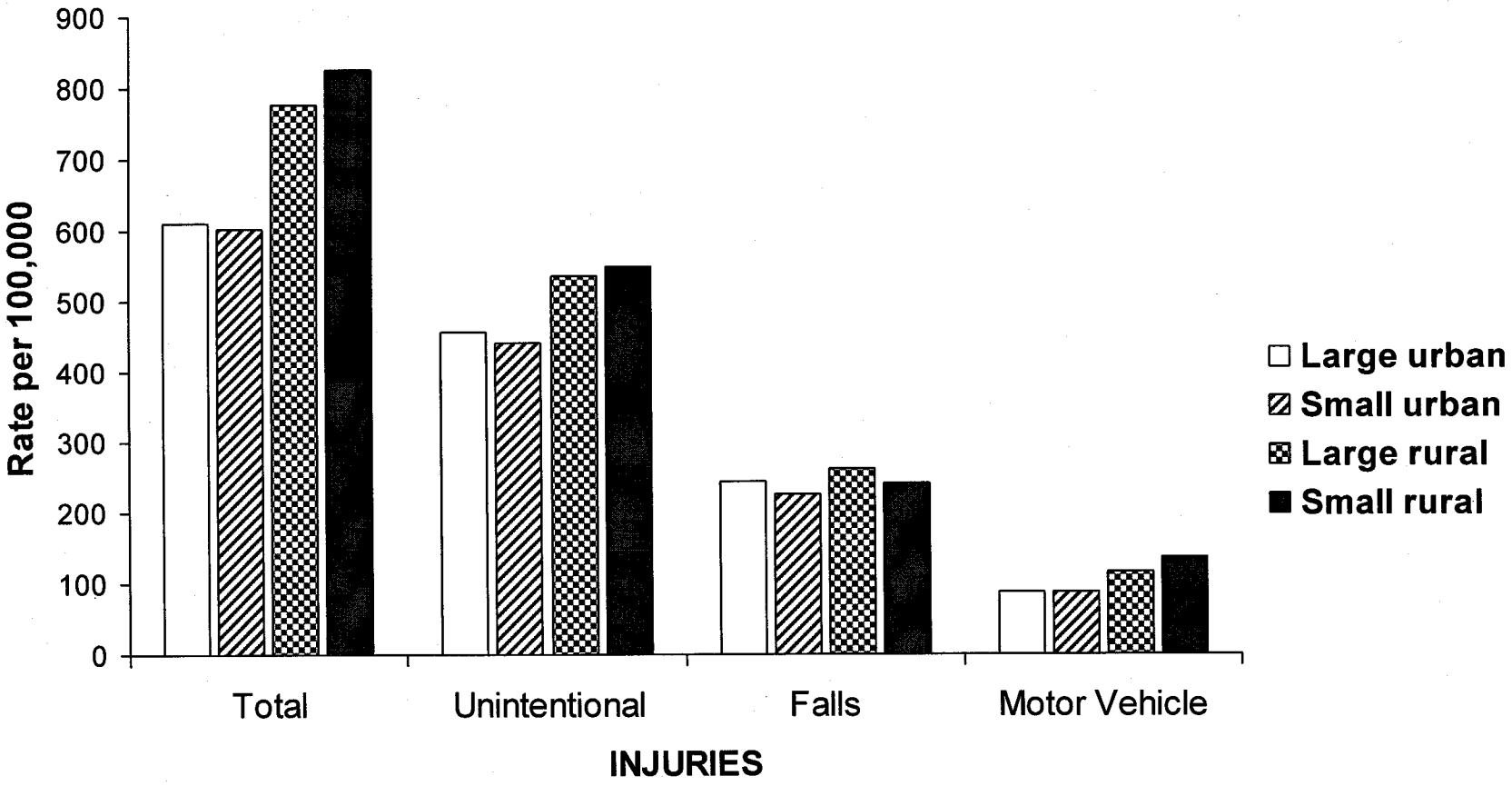


Figure 3. Injury hospitalization rates overall and for selected causes, by urbanization, United States, 2004.*+



*Coben JH, et al. Rural-urban differences injury hospitalizations in the U.S., 2004. Am J Prev Med 2008;36;49-55.
+Data source – 2004 National Inpatient Sample.

[NOTE: This type of assessment would be possible to do for Montana if HB 105 were passed.]